

		FOR OFF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045781

Facility Name: Odin Health Care Center

Address: 300 N. Green Street Odin 62870  
Number City Zip Code

County: Marion

Telephone Number: 618-775-6444 Fax # 618-775-6964

IDPA ID Number: 35-1921817003

Date of Initial License for Current Owners: 06/07/1994

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: Lee Grigsby Telephone Number: (832) 467-6244

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	Martha McDaniel	
	(Title)	Reimbursement Manager	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	( )	Fax # ( )
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001		
	Phone # (217) 782-1630		

Facility Name & ID Number Odin Health Care Center

# 0045781 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,045</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>66</u>	Intermediate (ICF)	<u>66</u>	<u>24,090</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,543</u>	<u>0</u>	<u>7,739</u>	<u>9,282</u>	8
9	SNF/PED					9
10	ICF	<u>18,618</u>	<u>5,008</u>	<u>122</u>	<u>23,748</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,161</u>	<u>5,008</u>	<u>7,861</u>	<u>33,030</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 91.41%

D. How many bed-hold days during this year were paid by the Department?  
7 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 6/7/1994

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 6/7/1994 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 33 and days of care provided 7,739

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number      **Odin Health Care Center**      #      **0045781**      Report Period Beginning:      **01/01/2005**      Ending:      **12/31/2005**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	149,107	21,928	911	171,946		171,946		171,946			1
2	Food Purchase		137,656		137,656		137,656		137,656			2
3	Housekeeping	96,444	11,232		107,676		107,676		107,676			3
4	Laundry	47,321	4,310		51,631		51,631		51,631			4
5	Heat and Other Utilities			105,542	105,542		105,542	42	105,584			5
6	Maintenance	39,613	35,364		74,977		74,977	165	75,142			6
7	Other (specify):* <b>Waste Garbage-See pg 3.1</b>			13,955	13,955		13,955		13,955			7
8	<b>TOTAL General Services</b>	332,485	210,490	120,408	663,383		663,383	207	663,590			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			11,501	11,501		11,501		11,501			9
10	Nursing and Medical Records	1,350,281	135,196	17,907	1,503,384		1,503,384	13,213	1,516,597			10
10a	Therapy	500,210	53,604	26,265	580,079		580,079		580,079			10a
11	Activities	33,450	4,429	2,275	40,154		40,154		40,154			11
12	Social Services	37,000	2,370		39,370		39,370		39,370			12
13	CNA Training			9	9		9		9			13
14	Program Transportation	12,073	63	6,971	19,107	(6,971)	12,136	(63)	12,073			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,933,014	195,662	64,928	2,193,604	(6,971)	2,186,633	13,150	2,199,783			16
	<b>C. General Administration</b>											
17	Administrative	83,577			83,577		83,577		83,577			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			28,044	28,044		28,044	(13,115)	14,929			20
21	Clerical & General Office Expenses	146,733	10,629	314,670	472,032		472,032	(112,941)	359,091			21
22	Employee Benefits & Payroll Taxes			598,765	598,765		598,765		598,765			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,632	25,632		25,632	12,233	37,865			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,283	88,283		88,283		88,283			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	230,310	10,629	1,055,394	1,296,333		1,296,333	(113,823)	1,182,510			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,495,809	416,781	1,240,730	4,153,320	(6,971)	4,146,349	(100,466)	4,045,883			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Facility Name & ID Number

Odin Health Care Center

#

0039503

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	10,264
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	3,691
Garbage Service <> Default <> Physical Plant	0
	13,955

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over \$2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2005 Page -3.2  
Ending: 12/31/2005

Facility Name & ID Numbe Odin Health Care Center # 0039503

Meals - adjustment

33,030 Days ( Total Patient days)  
3 Mult (3 meals a day)  
99090 Sub total  
0 meals to employess (reported by facility)  
99090 Add Sub  
0 Divide -Pg 3, line 2, column 2  
0.00 Cost per day

Sales Tax - adjustment

137,656 Total Food Cost (page 3,Line 2, col 3)  
0.01 Mult  
1376.56 Sub total  
34.32% Mult (Pvt pay div by total census)  
473 x 1/2

0.00 Cost per day  
0 mult - meal to employees  
0 = adjust for pg 2, line 2, column2

236 = adjust for nonallowable sale tax  
for page 5A,

Reclassifiaction V

Page 3 Line 14  
Res/Client Transportation<>Default<>Prod<>Transport Non<>Emerg 810004000003850 (6,971) Reclass From  
Page 4 line 38 6,971 Reclass to

Page 4 line 30 Depreciation  
Depreciation Transportation<>PS AM Capital Expenditures<>FS<>R 911745171008220 0

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			3,387	3,387		3,387		3,387			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(119)	(119)		(119)	119				32
33	Real Estate Taxes			41,411	41,411		41,411	1,041	42,452			33
34	Rent-Facility & Grounds			514,585	514,585		514,585	(85,540)	429,045			34
35	Rent-Equipment & Vehicles			163	163		163	10,163	10,326			35
36	Other (specify):*							12,989	12,989			36
37	TOTAL Ownership			559,427	559,427		559,427	(61,228)	498,199			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					6,971	6,971	(6,971)				38
39	Ancillary Service Centers		189,525	30,737	220,262		220,262	20,367	240,629			39
40	Barber and Beauty Shops			612	612		612	(612)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		189,525	85,552	275,077	6,971	282,048	12,784	294,832			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,495,809	606,306	1,885,709	4,987,824		4,987,824	(148,910)	4,838,914			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Report Period Beginning: 01/01/2005 Page -4.1

Facility Name & ID Number      Odin Health Care Center      #      0039503      Ending:      12/31/2005

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankruptcy Exp Acq <> Cost Non Overheac	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
	-

Rent-Facility & Grounds - Expenses Line 34 Column 7	
Lease Expense Facility-Realty-Default-Prod	85,563
	0
	0
	0
	85,563

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Sales Taxes	\$ (230)	21	1
2	Small Balance Adjustment		21	2
3	Memorium/ Benevolance	(951)	21	3
4	Depreciation Reconciliation		30	4
5	Activities Program Receipts		11	5
6	Property Taxes Adjust to actual		33	6
7	Professional liability Insurance		26	7
8	Barber & beauty	(612)	40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(13,974)	20	10
11	Entertainment	(118)	24	11
12	Fresh Start		36	12
13	Civic Dues		20	13
14	Penalties		21	14
15	Vending reciepts		21	15
16	Misc Reciepts		21	16
17	Marketing Wages		21	17
18	Marketing Bonus		21	18
19	Marketing Holiday		21	19
20	Maketing Sick		21	20
21	Marketing Vacation		21	21
22	Marketing Overtime		21	22
23	Marketing Non Worked Wages		21	23
24	Donations/ Contributions	(50)	21	24
25	Legal Fees - Bankrupcty		21	25
26	Legal Structure Management Fees	(276,620)	21	26
27	Transportation	(63)	14	27
28	Undocumented Travel		24	28
29	Interest Income	119	32	29
30	Rent Averaging	(85,563)	34	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(378,062)		49

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(6,971)	38		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,934)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(292,499)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (317,404)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	254,057		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 254,057		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (63,347)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$ 6,971	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 6,971		47

## Summary A

**12/31/2005**

[illegible]

## Summary B

**12/31/2005**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings, LLC	100	See Attachment page 6.1		SSC Equity Holdings I	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	SSC Equity Holdings, LLC	100.00%	\$ 42	\$	42
2	V	6	Repair & Maintenance		SSC Equity Holdings, LLC	100.00%	165		165
3	V	39	Professional Services		SSC Equity Holdings, LLC	100.00%	20,367		20,367
4	V	20	Fees, Subscriptions, Promotions		SSC Equity Holdings, LLC	100.00%	859		859
5	V	10	Nursing & Medical Records		SSC Equity Holdings, LLC	100.00%	13,213		13,213
6	V	21	Clerical & General Office Exp		SSC Equity Holdings, LLC	100.00%	182,844		182,844
7	V	24	Travel & Seminar		SSC Equity Holdings, LLC	100.00%	12,351		12,351
8	V	26	Insurance Premium		SSC Equity Holdings, LLC	100.00%			
9	V	36	Depreciation		SSC Equity Holdings, LLC	100.00%	12,989		12,989
10	V	33	Taxes - Property		SSC Equity Holdings, LLC	100.00%	1,041		1,041
11	V	35	Rental & Leasing		SSC Equity Holdings, LLC	100.00%	10,163		10,163
12	V	34	Leasse Expense		SSC Equity Holdings, LLC	100.00%			23
13	V	26	Property Insurance		SSC Equity Holdings, LLC	100.00%			
14	Total			\$			\$ 254,034	\$ *	254,057

\* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Report Period: Beginning: 1/1/2005 Page -6.1

Facility Name & ID Number: Odin Health Care Center # 0039503

Ending: 12/31/2005

Related Illinois Nursing Homes  
as of  
12/31/2005

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
SSC Equity Holdings, LLC	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number      Odin Health Care Center      #      0045781      Report Period Beginning:      01/01/2005      Ending:      2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)      YES ☒      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization      SSC Equity Holdings, LLC  
Street Address      One Ravinia Dr. Suite 1400  
City / State / Zip Code      Atlanta, GA 30346  
Phone Number      ( 770) 829-5100  
Fax Number      ( 770) 393-8054

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		\$ 42	\$	1	\$ 42	1
2	6	Repair & Maintenance		1		165		1	165	2
3	39	Professional Services		1		20,367		1	20,367	3
4	20	Fees, Subscriptions, Promotions		1		859		1	859	4
5	10	Nursing & Medical Records		1		13,213		1	13,213	5
6	21	Clerical & General Office Exp		1		182,844		1	182,844	6
7	24	Travel & Seminar		1		12,351		1	12,351	7
8	26	Insurance Premium		1				1	0	8
9	36	Depreciation		1		12,989		1	12,989	9
10	33	Taxes - Property		1		1,041		1	1,041	10
11	35	Rental & Leasing		1		10,163		1	10,163	11
12	34	Leasse Expense		1		23		1	23	12
13	26	Property Insurance								13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 254,057	\$		\$ 254,057	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6														6					
7														7					
8														8					
9	TOTAL Facility Related						\$		\$			\$		9					
	B. Non-Facility Related*																		
10														10					
11														11					
12														12					
13														13					
14	TOTAL Non-Facility Related						\$		\$			\$		14					
15	TOTALS (line 9+line14)						\$		\$			\$		15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Odin Health Care Center

COUNTY

Marion

FACILITY IDPH LICENSE NUMBER

0045781

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE

832-467-6244

FAX #:

832-467-6246

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	10-11-400-001	00000000 PT SE SE	\$ 47,077.32	\$ 47,077.32
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 47,077.32	\$ 47,077.32

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **42,500**

B. General Construction Type: Exterior **Brick** Frame **Steel** Number of Stories **1**

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	269,000	1994	\$ 80,743	1
2					2
3	TOTALS	269,000		\$ 80,743	3

Facility Name & ID Number    **Odin Health Care Center**#    **0045781**

Report Period Beginning:

01/01/2005    Ending:    12/31/2005

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1994	1995	\$ 3,360,767	\$ 96,022	35	\$ 96,022	\$	\$ 1,014,902	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	See Attached -Page 12.1			1994	782,958	39,148	20	39,148		412,688	9
10	Repair Sidewalk #36 & 37			1996	819	41	20	41		339	10
11	Rooftop A/C - See attached page 12.2			1996	16,378	819	20	819		8,115	11
12	Install Awning			1997	2,845	142	20	142		1,115	12
13	Water Heater - See page 12.2			1997	1,388	69	20	69		597	13
14	Water Heater Installed - See page 12.2			1997	6,645	332	20	332		2,886	14
15	Electrical			1998	357	9	20	9		63	15
16	HVAC			1998	1,516	38	20	38		266	16
17	Plumbing # 67			1998	2,853	71	20	71		497	17
18	Water Heater # 69			1998	3,885	97	20	97		679	18
19				1999							19
20											20
21											21
22	A.O. Smith 75 Gal Gas # 72			1999	1,818	182	10	182		1,092	22
23	100 G Gas Water Heater # 77 & 78			2000	1,397	140	10	140		653	23
24	12: Zoneline HVAC Units #94 & 95			2000	8,579	572	15	572		2,574	24
25	First Q digital reset #98 & 99			2000	1,224	122	10	122		570	25
26	W/G & Maglocks system #102 & 103			2000	3,817	382	10	382		1,655	26
27	2200 SQ FT Flatroof Downpymt #104			2000	9,899	990	10	990		4,207	27
28	Wandergard System #106 & 107			2000	3,615	362	10	362		1,688	28
29	236' 4' High, DogEar Cedar Fence #109			2000	3,173	397	8	397		1,719	29
30	Instl 11,220 SQFT Flat roof #110			2001	20,098	2,010	10	2,010		5,039	30
31	Roof Shingles - 33% Downpmt #111			2001	18,277	1,828	10	1,828		7,006	31
32	Balance of Roof Replacmt #112			2001	36,553	3,655	10	3,655		13,707	32
33	9: Smoke & 2: Heat Detectors #116			2001	960	96	10	96		360	33
34	Use Tax 9: Smoke & 2: Heat Detectors #117			2001	62	3	10	3		17	34
35	R/T 3T Armstrong Condense Int #118			2001	1,278	85	15	85		312	35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**See Page 12A, Line 70 for total**

Facility Name & ID Number    **Odin Health Care Center**#    **0045781**

Report Period Beginning:

01/01/2005    Ending:    12/31/2005

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	4: Maglocks & Indoor Keypads #119	2001	\$ 3,057	\$ 306	10	\$ 306	\$	\$ 1,451	37
38	7: Zoneline HVAC - Patient Rooms #123	2001	4,718	315	15	315		1,390	38
39	Use Tax 7: Zoneline HVAC - Patient Rooms #124	2001	298	20	15	20		88	39
40	Charge Back - Excessive Discount #126	2001	442	29	15	29		127	40
41	5: Catch - All Digital Reset #127	2001	1,577	158	10	158		736	41
42									42
43	3: Wanderguard Auto 24Hr timer #144	2002	250	25	10	25		117	43
44	Cr Inv# 10017115 - 1; Auto 24 Hr timer #145	2002	(76)	(8)	10	(8)		(35)	44
45	Wanderguard System Unst'l #146	2002	2,680	268	10	268		1,819	45
46	6: Zoneline Heat/ Cool Units #5017	2002	4,111	822	5	822		2,946	46
47	Use Tax 6: Zoneline Heat/ Cool Units #5018	2002	260	52	5	52		186	47
48	Repair to Damage Brick #5030	2002	5,000	333	15	333		418	48
49	Arch fee -Upgrade to Skilled St #5033	2002	1,928	129	15	129		418	49
50									50
51	Prefinished Slab Door #5034	2003	495	33	15	33		102	51
52	SteelDoor w/Window # 5035	2003	693	35	20	35		107	52
53	15: Vinyl Rplc Window -Intsl # 5036	2003	7,500	500	15	500		1,542	53
54	Sentricon colony Elim -instl # 5051	2003	8,890	889	10	889		2,445	54
55	Arch/Eng Fee Skilled Care # 5054	2003	5,143	342	15	342		913	55
56	Cable - remote -WanderGuard system # 5059	2003	2,546	255	10	255		1,167	56
57	2: Maglock -WanderGuard # 5063	2003	(2,338)	(234)	10	(234)		(1,305)	57
58	6: Zoneline a/C Units A/C Heat Units # 5056	2003	3,434	687	5	687		1,717	58
59	Use Tax -6: Zoneline a/C Units A/C Heat Units # 5056	2003	216	43	5	43		108	59
60	2: Window Shutters - Fire Saftey # 5069	2003	3,376	225	15	225		563	60
61	Rpr 2 Floors Drain -Kitchen # 5079	2003	1,750	88	20	88		212	61
62	Rplc 91 Gal Gas Waterheater #5082	2003	2,380	238	10	238		536	62
63									63
64	Fire Sentinel-Dr Release Device	2004	1,948	141	15	141		282	64
65	Wet Sprinkler Syst Instl	2004	8,226	329	25	329		658	65
66	UseTax - Fire Sentinel A Door	2004	107	8	15	8		16	66
67	Engineering Services	2004	3,639	182	15	182		364	67
68	Fire Suppression Syst	2004	1,961	114	10	114		228	68
69	6: Zoneline Heat/ Cool Units	2004	3,434	143	10	143		286	69
70	TOTAL (lines 4 thru 69)		\$ 4,368,808	\$ 154,078		\$ 154,078	\$	\$ 1,502,348	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number    Odin Health Care Center

#    0045781

Report Period Beginning:

01/01/2005    Ending:    12/31/2005

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,368,808	\$ 154,078		\$ 154,078	\$	\$ 1,502,348	1
2	<b>Use Tax-6: Zoneline Heat/ Cool Units</b>	2004	223	9	10	9		18	2
3									3
4	<b>Facility Repair</b>	2005	38,961	1,515	15	1,515		1,515	4
5	<b>Sewer Line Repairs, Add Pipe</b>	2005	1,664	33	25	33		33	5
6	<b>Repairs Main Sewer Line</b>	2005	550	11	20	11		11	6
7	<b>Inspect Main Trunk Line</b>	2005	325	7	20	7		7	7
8	<b>4:Smoke Detectors</b>	2005	675	23	10	23		23	8
9	<b>Tile &amp; Security Alarm Oxygen</b>	2005	232	5	15	5		5	9
10	<b>10 Ton Seer Condenser/AC Unit</b>	2005	1,450	32	15	32		32	10
11	<b>Ruud Air Handler-Instl</b>	2005	1,650	14	20	14		14	11
12	<b>2:Zoneline Heat/Cool Units</b>	2005	1,119	93	15	93		93	12
13	<b>Fascia Board Repair</b>	2005	3,520	98	15	98		98	13
14	<b>Facility Repair</b>	2005	37,013	617	25	617		617	14
15	<b>Sewerline Repairs, Add Pipe</b>	2005	1,620	16	15	16		16	15
16	<b>Repairs Main Sewer Line</b>	2005	534	7	15	7		7	16
17	<b>Inspect Main Trunk Line</b>	2005	316	4	10	4		4	17
18	<b>4:Smokie Dectors</b>	2005	641	16	10	16		16	18
19									19
20	<b>10 Ton Condenser-A/C Unit</b>	2005	1,402	23	15	23		23	20
21	<b>Ruud Air handler-Instalation</b>	2005	1,622	20	20	20		20	21
22	<b>Use Tax-2: Zoneline Heat/ Cool Units</b>	2005	70	6	5	6		6	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,462,394	\$ 156,627		\$ 156,627	\$	\$ 1,504,906	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$442,033	\$39,563	\$39,563	\$		\$402,470	71
72	Current Year Purchases	10,306,391						72
73	Fully Depreciated Assets	(10,473,056)						73
74								74
75	TOTALS	\$275,371	\$24,883	\$39,563	\$		\$250,488	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activities & Trans	White Ford Van 2003	2003	\$40,166	\$10,042	\$10,042	\$	3	\$24,164	76
77										77
78										78
79										79
80	TOTALS			\$40,166	\$10,042	\$10,042	\$		\$24,164	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,858,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$191,552	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$206,232	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,779,558	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 06/01/1996	\$2,579	\$129	\$1,043	86
87	O/H Allocation 08/01/1997	1,035	52	386	87
88	O/H Allocation 10/01/1997	117	6	80	88
89					89
90					90
91	TOTALS	\$3,731	\$187	\$1,509	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:SSC Odin Operating Company, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		99	01/01/2005	\$429,021	20		3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$429,021			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:

☐ YES

☐ NO

Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES

☐ NO
16. Rental Amount for movable equipment: \$20,252Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning01/01/2005

Ending12/31/2024

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

STATE OF ILLINOIS

Report Period:      Beginning:    1/1/2005      Page -14.1  
Ending:      12/31/2005

Facility Name & ID Number      Odin Health Care Center      # 0039503

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount	Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Mattress	11444.71	03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000			03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Dishwasher	911.00	03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeeping	841000000007040			03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050			03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admin	841000000008000			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copiers, Stamp machine Cable	7,896.00	03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plant	841000000008210			03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220			04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100			03/21/03
			20,251.71 Grand Total	

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-03	6,841	hrs	\$ 204,861		\$	\$	6,841	\$ 204,861	1
2	Licensed Speech and Language Development Therapist	10a-03	3,619	hrs	119,375				3,619	119,375	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	10a-03	7,488	hrs	184,753				7,488	184,753	4
5	Physician Care	39		visits							5
6	Dental Care	39		visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				189,525		189,525	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				\$ 508,989		\$	\$ 189,525	17,948	\$ 698,514	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 550	\$ 22,735	1
2	Cash-Patient Deposits	22,735		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	347,095		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	198		6
7	Other Prepaid Expenses	64,172		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 434,750	\$ 22,735	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	59,224		16
17	Accumulated Depreciation (book methods)	(1,848)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Lease Hold Rights</u>	53,431		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 110,807	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 545,557	\$ 22,735	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 190,735	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	147,550		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,716		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,667		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attachment Schd 17.1</u>	51,500		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 425,168	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attachment Schd 17.1</u>	(4,076,758)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (4,076,758)	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (3,651,590)	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,197,147	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 545,557	\$	48

\*(See instructions.)

STATE OF ILLINOIS

Facility Name & ID Number Odin Health Care Center # 0039503

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

OTHER CURRENT ASSETS: AMOUNT

OTHER CURRENT LIABILITIES: AMOUNT

Misc Dedctns - Employee <> Other Decductions <> Default	977
Misc Dedctns - Employee <> Union Dues <> Default	-
Accruals - Insurance <> Accrue HMO Ins <> Default	5
Accruals - Insurance <> Self Funded Ins Accr <> Default	38,558
Accruals - Insurance <> Basic Life <> Default	871
Accruals - Insurance <> Lt Dsblty <> Default	162
Accruals - Insurance <> Dental Ins <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	441
Accruals - Insurance <> Short Term Disability <> Default	676
Accruals - Insurance <> Dependent Life <> Default-Dept	9
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	35
Accruals - Insurance <> NES Insurance <> Default-Dept	750
Medicaid Revenue-Ancillary Rev {General}-Contr Adj	9,017

Total 0 Difference

Total 51,501 Difference

Reconcile with schedule XV, line 9: 0 0

Reconcile with schedule XV, line 36: 51,501 -

OTHER NON-CURRENT ASSETS:

Excess Reorganized Value <>Excess Reorg Value <> Default  
Other Assets <> Rfindable Deposits-Non Int Brg <> Default

OTHER NON-CURRENT LIABILITIES::

N/P - Mortgage <> Mortgages <> Default	-
Mortgage Cost <> Current Position <> Default	0
Long Term Debt - Other <> Other <> Default	0
I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	-232124.79
Intercompany - Revolver <> Default <> Default	-4087987.17
I/C Term Loan 1998 <> Default-Prod <> Default-Dept	0
I/C Term Loan 1999 <> Default-Prod <> Default-Dept	0
I/C - Interunit Asset Transfer <> Default-Prod <> Default-Dept	0
Intercompany Revolver - SSC-Default-Dept-Default-Prod	16310.76
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	134349.49
Compromised Liabilities <> Default	0
Other Non-Current Lby <> Rent Accrual <> Default	92693.33
Other Non-Current Lby <> Other <> Default-Dept	0
Other Non-Current Lby <> Overmarket Lease <> Default-Dept	0

Total - Difference

Total (4,076,758) Difference

Reconcile with schedule XV, line 23: 0 -

Reconcile with schedule XV, line 43: (4,076,758) 0

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,670,417	1
2	Restatements (describe):		2
3	Asset Transfer	(1,019,303)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,651,114	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	546,033	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 546,033	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,197,147	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,789,089	1
2	Discounts and Allowances for all Levels	(2,597,315)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,191,774	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,749,392	6
7	Oxygen	50,886	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,800,278	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	362,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	124,782	19
20	Radiology and X-Ray	8,950	20
21	Other Medical Services	43,646	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 540,361	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28		1,444	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,444	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,533,857	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	663,383	31
32	Health Care	2,193,604	32
33	General Administration	1,296,333	33
	<b>B. Capital Expense</b>		
34	Ownership	559,427	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	220,874	35
36	Provider Participation Fee	54,203	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,987,824	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	546,033	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 546,033	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Report Period:      Beginning:      1/1/2005      Page -19.1  
Ending:      12/31/2005

Facility Name & ID Number      Odin Health Care Center      #      0039503

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0
Miscellaneous Receipts<>Default<>Prod<>Vending	1444
Miscellaneous Receipts<>Default<>Prod<>Administrative	-

Total	1,444.00	Difference
Reconcile with schedule XVII, line 28:	1,444	0

DESCRIPTIONS

Personal Purchase Receipts <> Default <> Patient Personal Purc	-
Personal Purchase Receipts <> Default <> Miscellaneous Receip	-
Personal Purchase Expense <> Default <> Patient Personal Purc	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	

Total	-	Difference
Reconcile with schedule XVII, line 28a:	0	-

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,169	2,182	\$ 47,028	\$ 21.55	1
2	Assistant Director of Nursing	1,128	1,135	22,942	20.21	2
3	Registered Nurses	11,057	11,123	228,409	20.53	3
4	Licensed Practical Nurses	21,447	21,576	333,432	15.45	4
5	CNAs & Orderlies	70,432	70,856	622,916	8.79	5
6	CNA Trainees					6
7	Licensed Therapist	10,932	11,014	239,961	21.79	7
8	Rehab/Therapy Aides	7,807	7,865	284,855	36.22	8
9	Activity Director	2,177	2,177	21,578	9.91	9
10	Activity Assistants	1,637	1,637	9,878	6.03	10
11	Social Service Workers	3,071	3,071	34,683	11.29	11
12	Dietician					12
13	Food Service Supervisor	1,888	1,888	17,742	9.40	13
14	Head Cook	6,932	6,932	50,573	7.30	14
15	Cook Helpers/Assistants	9,797	9,797	70,735	7.22	15
16	Dishwashers					16
17	Maintenance Workers	2,835	2,845	31,866	11.20	17
18	Housekeepers	13,041	13,041	94,452	7.24	18
19	Laundry	6,114	6,114	45,328	7.41	19
20	Administrator	2,169	2,180	86,619	39.73	20
21	Assistant Administrator					21
22	Other Administrative	3,361	3,376	63,686	18.86	22
23	Office Manager					23
24	Clerical	5,135	5,161	61,929	12.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,062	2,090	18,309	8.76	31
32	Other Health Care Medicare Coord.	4,493	4,493	98,679	21.96	32
33	Other(specify) Mktg & Transpo	1,339	1,339	10,209	7.62	33
34	TOTAL (lines 1 - 33)	191,023	191,892	\$ 2,495,809 *	\$ 13.01	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	289	\$ 11,141	1-3	35
36	Medical Director	48	11,000	9-3	36
37	Medical Records Consultant	37	1,650	10-3	37
38	Nurse Consultant	272	13,213	10-7	38
39	Pharmacist Consultant	63	2,688	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,813	11-3	44
45	Social Service Consultant	40	2,177	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	782	\$ 43,682		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

<b>Facility Name &amp; ID Number</b>	<b>Odin Health Care Center</b>
--------------------------------------	--------------------------------

# 0045781

**Report Period Beginning:** 01/01/2005

**Ending: 12/31/2005**



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Hlth Care Assoc.-\$4340.20
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.    \$ 13,830 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement?    YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.    \$ 54,203  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.    \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? N/A If YES, please indicate the amount of income earned from such a program during this reporting period.    \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period.    \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees